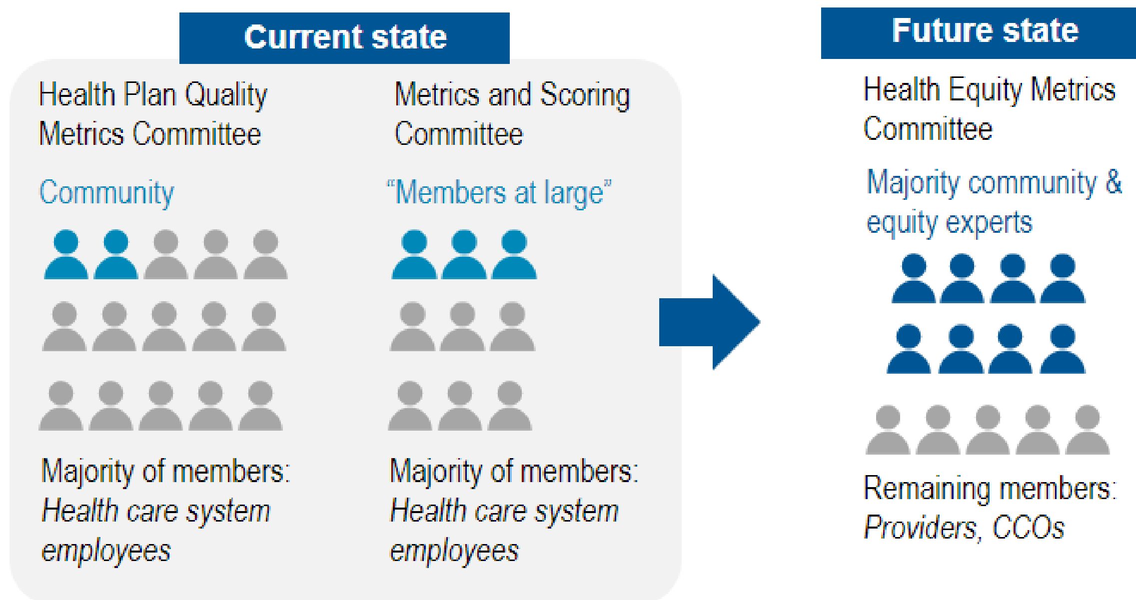
Background on Proposal to increase health equity via Oregon's Quality Incentive Program

The Coordinated Care Organization (CCO) Quality Incentive Program (QIP) encourages CCOs to improve the quality of care for people who are members of the Oregon Health Plan (OHP). OHP members experience some of the highest rates of health inequities in the state. CCOs earn bonuses based on how well they perform on specific health care access & quality measures.

To meet health equity goals, the QIP must be redesigned

The current structure places most decision-making power with health care system employees rather than people who are OHP members and other priority populations whose health may be impacted by the measures. Today, two public committees make decisions about the QIP. Health Plan Quality Metric Committee (HPQMC) sets the list of measures that Metrics and Scoring Committee can use. Then Metrics and Scoring Committee (MSC) chooses measures to incentivize and sets payment benchmarks and improvement targets.



To achieve health equity, priority populations should lead decision-making

SB967 would replace the current committee structure with one community-led Health Equity Quality Metrics Committee (HEQMC).

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At least eight of HEQMC's members would be OHP members, community representatives, and health equity researchers and professionals, and four members would be from CCOs, providers and the health care system.

Redesigning the QIP to increase health equity

The human impact of the current QIP structure

Between 2022 and 2023, about one third of benchmarks decreased or stayed the same, while bonus dollars increased by $50 million. Decreased benchmarks can undo progress toward exceptional care. For example**:**

- In 2022, one benchmark required that CCOs aspire to give brief interventions[1] to slightly more than half (53.5%) of OHP members who screen positive for potentially problematic substance[2] use. In 2023, the benchmark for the same metric was reduced to 28.7% — a nearly 25 percentage point reduction.
- This reduction represents **5,000 fewer OHP members who screen positive for potentially problematic substance use being given a brief intervention**, even as CCOs still qualify for bonus dollars.[3]

More information about the current structure

- **When the QIP was created in 2013, it was not designed to achieve health equity.** In recent years, OHA received OHP member feedback that health equity must be a QIP focus. The 2021 MSC Equity Impact Assessment also found making program changes and increasing OHP member participation was vital to centering health equity.
- **The bonus money that CCOs receive has increased over time.** Bonus dollars have increased from $47 million for 2013 to over $300 million for 2022.
- **OHA distributes all funds allocated to the QIP each year** regardless of CCO performance; no funds are held back or carried over.
- **A CCO can meet either improvement targets or benchmarks and still receive their entire QIP bonus.** Improvement targets are lower than benchmarks and unique to each CCO.
  - **Some improvement targets are very low.** For 2022, some improvement targets required less than 0.1% improvement over 2021 performance. Learn more about how improvement targets are calculated.
- **To get credit for a measure, CCOs performance can vary widely.** For 2022 performance, MSC set the Depression Screening and Follow-Up measure benchmark at 64.6%. Not all CCOs will need to meet that level of performance to earn their bonus

[1] Brief interventions include things like conversations and referrals. Learn more.
[2] See measure information.
[3] Estimate based on 2021 screening data.

dollars. For this measure, the lowest improvement target is 29.2% - meaning that one CCO can achieve the measure by screening 3 out of 10 patients for depression.

Definitions

Benchmark: The benchmark is the goal that a CCO is striving to reach. For example, it might be the percentage of patients who receive a certain type of screening or follow-up care.

Improvement target: Improvement targets are measurable progress toward the benchmark. They are assigned to CCOs that have not reached the benchmark. CCOs can earn bonus dollars for reaching their improvement target, rather than the benchmark.

The QIP has two types of improvement targets:

1. Make adequate progress as defined by the Minnesota Method[4]
2. Increase by a specific percentage point as defined by the Target Floor if the Minnesota method would result in a smaller improvement than the Target Floor

Measure: Performance measures assess health care processes, outcomes, patient experiences, and more. OHA and the Centers for Medicare and Medicaid use measures to track progress toward goals, including effective, safe, efficient, patient-centered, equitable, and timely care.

For more information:

Philip Schmidt, OHA Government Relations
503-383-6079
philip.schmidt@dhsoha.state.or.us

[4] If the CCO didn't meet the new benchmark in the previous year, they can achieve a measure by surpassing the benchmark or meeting its improvement target. The percentage point change for the Minnesota Method is the (Benchmark – previous year performance) divided by 10. This means that if a CCO scored 30% in the previous year and the benchmark is now 40%, the improvement target is (40-30)/10 or 1%. The CCO needs to obtain a score of 30% + 1% or 31% to meet the Minnesota Method target. If MSC set a target floor of 2% for the same measure and since the target floor is greater than the 1%, the CCO would need a score of 30% + 2% or 32%.

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